IN THE CIRCUIT COURT OF THE
FOURTH JUDICIAL CIRCUIT IN
AND FOR DUVAL COUNTY FLORIDA

CASE NO 95-00934-CA

DIVISION CV B

GRADY CARTER and
MILDRED CARTER,

Plaintiffs,

vs.

BROWN & WILLIAMSON TOBACCO
CORPORATION as successor by
merger to THE AMERICAN TOBACCO
COMPANY

Defendant.

PROCEEDINGS

August 5, 1996

VOLUME XI

Pages 3136 - 3264

INDEX

Witness JOHN W THOMPSON M D

PROCEEDINGS

Monday, August 5, 1996 2 20 p.m.

MR WILNER Your Honor, apparently there is a videotape that is being offered, and I'd like to see it before it is shown to the jury

THE COURT All right

MR WILNER Your Honor, while they are setting up, the issue may arise that Dr Thompson -- is that Dr Thompson? I would like Dr Thompson to step out for my remarks, if I might

THE COURT Is that Dr Thompson leaving?

MR WILNER Yes, he is leaving If you recall, the issue of Dr Thompson -- a psychiatrist's ability to obtain an involuntary examination of Mr Carter was debated in pretrial Your Honor ruled that that was not something that would pertain in this case I feel it would be improper for Dr Thompson to state or to be asked, Would you want -- or did you want to see Mr Carter? And then to answer, Yes, I did, but Mr Carter wouldn't let me, or words to that effect

The whether Mr -- the reason that I think that would be improper is because it wasn't

Mr Carter not permitting an examination Mr Carter is entitled to have his rights adjudicated by Your Honor, and that's not -- I think something -- that's like commenting on a party's position

I think that the question, Did you examine Mr Carter, is proper But I think the why didn't you is not, because it indicates something that Mr Carter did or didn't do whereas we have -- it was something debated as to whether the law permitted it, and Your Honor ruled that it did not So that would be our motion is to preclude mention that Mr Carter refused an examination or any words or suggestion to that effect

THE COURT Mr Riley

MR RILEY Your Honor, I think Dr Feingold and Dr Yergin both came into the courtroom and discussed with the jury discussions and conversations they had with Mr Carter about his cigarette smoking I think it's unfair to put us in the position where our witness has not had that opportunity for us to be able to explain why he was not given that opportunity I think that's unfair

And as we've explained to the court before, we did have a concern, expressed the concern

Page 3140

to Your Honor that the jury might perhaps be led to give more credence to the testimony of either Dr Feingold or Dr Yergin because they had met Mr Carter and, in fact, Dr Thompson has not had that opportunity despite having asked for it So we think it's unfair to us to be put in this position So we would request, Your Honor, to be able to bring out the fact that he did request an opportunity to meet with Mr Carter

THE COURT I'm not going to allow him to testify to that effect I don't think that it comports with the court's earlier ruling that Mr Carter's right to privacy outweighed the defendant's perceived need to have him examined psychiatrically And I think that unfair inference of his failure to cooperate would be gleaned from his -- from the line of questioning that you propose So I am going to grant the plaintiffs' motion in limine

MR RILEY Your Honor, if the question is asked on cross-examination, I assume that the doctor would be permitted to explain that?

THE COURT That's an entirely different question We'll see what happens on cross-examination

Page 3141

How long is the video?

MR RILEY It's about 30 seconds Your Honor

THE COURT Mr Wilner, take a moment to view it I take it you haven't seen it?

MR WILNER No, not to my knowledge

(Playing videotape)

(Inaudible) smoking for one reason or another Do you have any helpful advice on how to conquer it? Well, I'm a little like the fellow who once said I don't know whether to start again, but I will never stop again Actually, of course, at first I was very into smoking from my life in the military and war And all that I was asked to do was to be more moderate about it No doctor ever told me to stop But for me it was easier to stop and I will only say this, I really believe if a person turns their mind to something else and quits pitying themselves about it they won't find it nearly as hard to quit smoking as they think

MR WILNER To which, Your Honor, we object to the testimony of Dwight David Eisenhower or Ike on the issue of -- medical issue of whether he had an easy time or not to quit smoking That appears to be hearsay in it's most -- and it's easy

Page 3142

to recognize It's an out-of-court statement made by somebody who's not here I don't see how it meets any of the hearsay criteria And he is not competent to testify about those issues It's not a medical issue It's not lay expertise Be like calling someone off the street to give an opinion on whether they found it easy or not

I think if counsel is trying to back-door this with this huge catchall wastebasket category of general public information, the danger of it confusing the jury as being -- as being listened to as something as a testimonial from a noted person on the ease at which they quit smoking would be outweighed or would outweigh any connection it might have with this general public knowledge if, in fact, this is even an issue of general public knowledge

So I object to it It's just an out -- it's just hearsay

MR RILEY Your Honor, there has been all sorts of out-of-court statements put into evidence by plaintiffs in this case I do believe that this relates to public awareness and public information with respect to cigarette smoking and whether it -- and specifically with respect to quitting cigarette smoking I think the tape reflects the fact that

Page 3143

there was interest at the time in the public about quitting I think we are entitled to put that before the jury and to argue about, in summation, about why information about quitting was pertinent and important to the public at the time and to show and demonstrate what the public was told about that I think it's all relevant I think it should come in, Your Honor

MR WILNER Your Honor, by that standard, I guess there is no more rule of evidence about anything, because I guess you could always back-door it by saying it's what the public was told, even though I'm having a hard time understanding how that's even relevant to this case, what the public was told about quitting in 1952

THE COURT What is that a broadcast of?

MR RILEY It's a broadcast of a news conference that President Eisenhower held, I believe the year was 1957 I think it was I'm not sure It was the late 1950s He was asked why he had quit smoking. He had had a heart attack at the time and was asked why he was -- why he quit and just offered advise to people about quitting

MR WILNER Well, Your Honor, if there were some context to it other than just Eisenhower

Page 3144

getting up and saying, Oh, come on, you can quit if you want It's not even clear in there that he has had a heart attack That hasn't even been stated We don't know where it was broadcast or how or who received it It's not been connected to the plaintiff It's something hanging out in space

I think without someone to connect that up and say, Yes, this is characteristic of -- even if we assume that public knowledge is an issue in and of itself, which I'm having a hard time with that, but I don't understand why public knowledge in and of itself is an issue But assuming that it is, because counsel appears to be going in that direction, without an expert to connect it to something, it's not -- it doesn't do anything It's just a videotape Who's going to testify who listened to it, who saw it?

It's not self-authenticating like a magazine article where you can argue, well, U S News and World Report, you can figure where it was sent But this is just a videotape of something I don't know what it is

MR RILEY There has been all sorts of evidence that Mr Wilner has put into the record that has not been connected to Mr Carter in any

Page 3145

way, shape or form He's put in all sorts of advertising Advertising from when before Mr Carter was even born He put in the -- an advertisement that American Tobacco Company ran in The New York Times in 1969 Mr Carter specifically said he never saw that statement And Mr Wilner was able to put it into evidence anyway

For him now to say that we need to show that Mr Carter saw that, I think, is completely inconsistent with the position he's taken previously

MR WILNER Well, if it's a statement by a party defendant, I agree it should go in regardless of whether Mr Carter saw it, just like any statements made by Mr Carter regardless of whether American Tobacco heard them can go in But as to a statement by a third party who happens to be the president or ex-president of the United States talking about cigarette smoking in a press interview is bizarre

I guess they are trying to get it in for the theory that one ought to accord great weight to Eisenhower's opinion on how hard it was for him to quit Well, what difference does that make?

MR RILEY Your Honor, he has put in

Page 3146

advertisements that are not just from American Tobacco Company He's put in advertisements from other manufacturers, companies that aren't even in this lawsuit, and brands of cigarettes that Mr Carter never even claimed to have smoked

MR WILNER And --

THE COURT Well, let me say this, advertising is materially different than a statement of a former chief executive of this nation I'm not going to allow president -- former President Eisenhower to testify in this case that it was easy for him to stop smoking, because I think the prejudicial value of that attaches to the head of this nation making that statement on a personal experience outweighs benefits that might be gained from this jury or to this jury So I'm not going to permit the videotape

Anything else?

MR WILNER No, Your Honor

THE COURT Anything else, Mr Riley?

MR RILEY I think we are ready, Your Honor

THE COURT Bring the jury in, Mr Forte

(Jury present at 2 32 p m)

THE COURT Please be seated Mr Riley,

Page 3147

call your next witness, please

MR RILEY Your Honor, the defendant calls Dr John Thompson

THE CLERK Stand up here, please Place your left hand on the Bible and raise your right hand You do solemnly swear that the evidence you give on this issue will be the truth, the whole truth, nothing but the truth, so help you God?

THE WITNESS I do

THE CLERK Here you are, sir

THE COURT Good afternoon, Doctor How are you today?

THE WITNESS I'm fine How are you today?

THE COURT If you want to put those papers on the witness stand, you can have them right up there If they are easier for you to manage, you can do that

THE COURT All right, Mr Riley

MR RILEY May I proceed, Your Honor?

THE COURT Yes, sir

DIRECT EXAMINATION

BY MR RILEY

Q Doctor, would you please tell the jury your name

Page 3148

A John W. Thompson, Jr , M D.
Q And you're a medical doctor?
A Yes.
Q Where do you live?
A I live in [DELETED] , which is a suburb of
Q Are you licensed to practice medicine?
A Yes, I am
Q Where are you licensed to practice?
A I'm licensed to practice in the state of Louisiana
Q And where do you practice medicine at this time?
A I practice at Tulane University in New Orleans, and I do contract work with the state in another town called Jackson, Louisiana
Q What's the name of the facility in Jackson?
A Feliciana Forensic Facility
Q Feliciana Forensic Facility?
A It's basically a 235-bed hospital where individuals who are adjudicated by the courts as not competent to go to trial or not guilty by reason of insanity go for treatment
Q Is there -- do they treat patients for

Page 3149

substance dependence at that facility, Doctor?
A Yes, when I was asked to start working there, there was a considerable problem with substance use in that about 70 percent of the population also had substance use disorders And so there is a significant percentage of the population that does
Q Do you participate in that treatment yourself?
A Yes, I do
Q What's your role in that treatment?
A Well, they asked me to come there and to develop a program for the patients because there wasn't anything there So we put together a program with psychiatrists and social workers and psychologists and nursing staff to -- so the patients would have a program And it's an eight-week treatment track that they have while they are at the facility
Q How long have you held your position at Tulane and at Feliciana?
A For three years, will be three years in September, actually
Q What did you do before you joined Tulane?
A I worked in New Orleans at the Ochsner

Page 3150

Addictive Behavior Unit and that was for approximately 15 months from June of '92 through August of 1993
Q We have heard the name Ochsner in this trial before Who was the facility named after that you're at now or --
A Alton Ochsner
Q And that's the same Alton Ochsner who's --
A Yes
Q What was the addictive behavior unit that you worked at?
A It's a 15-bed treatment unit, and primarily the individuals who are there had strict substance use problems So they were in because they either had alcohol problems or cocaine problems and various other drugs So we would treat them in an inpatient setting and then follow them after that in an outpatient setting
Q The patients -- just to bring you back to Feliciana -- what are the substances -- you said a high percentage of the patients there also had substance abuse problems What are the substances that they are there for, that they are having problems with?
A The two most common are alcohol and

Page 3151

cocaine Marijuana is also commonly used And occasionally we'll have individuals who have used heroin and other drugs, but primarily, though, is alcohol and cocaine
Q Doctor, would you please share with the jury your educational background, where you got your M D degree and where you did your training?
A Certainly I received my medical degree from the University of Texas medical branch in Galveston, and I was there from 1982 to 1986 After I finished there, I enrolled at the University of Florida here in Gainesville, Florida I was there from 1986 until 1990 That was a residency in psychiatry.
Q What was the last year of your residency in? Was there a specialty in that last year of residency?
A Yes, the last year was a specialty in forensic psychiatry So that is basically psychiatry in the law, issues that interface between the legal system and the psychiatric system
Q Can you explain a little bit more about how that would arise, forensic psychiatry; the situation that it comes up in?
A Sure Most psychiatrists have to deal

Page 3152

with legal issues in one way or another Sometimes the patients that we have in the hospital are out of touch with reality and may need to go into the hospital against their will, so the psychiatrist may be asked to go before the court and testify in those kinds of issues Or they may have to get medications against their will and go before the court There are a lot of other issues as well, so that I can be asked by the court to evaluate someone's competence to stand trial or to evaluate whether they met the criteria for sanity or insanity at the time of the offense

We oftentimes will evaluate issues involving medical practice or medical malpractice issues And then there is a civil side of forensic psychiatry where a person has a particular claim or needs to be evaluated in one way or the other by the court systems, and that's usually at the request of a attorney, and you evaluate individuals in that context as well

Q Have you specialized in forensic psychiatry since then, since your residency?

A Yes, when I was Ochsner, I was primarily focusing on the addiction issues And since I have been at Tulane, I have been working mostly in

Page 3153

forensic psychiatry We have a training program to train forensic fellows where we teach them at the facility -- I mean, at the facility and at Tulane And that's primarily my area of focus right now

Q What did you do between the time you completed your residency and the time you went to Ochsner?

A Well, I had a two-year commitment to the United States Air Force in the military, and so I went to San Antonio, Texas, at Wilford Hall Medical Center I spent two years there I was the director of one of the inpatient units there It was a training facility where we trained residents and we also treated patients The patients were either psychiatric patients or patients with substance use disorders And we would evaluate them and treat them, mostly detoxifying them so they could go into the alcohol program after that

Q What was your rank at discharge from the Air Force?

A I was a captain

Q Was that a honorable discharge?

A Yes

Q Would you please tell the jury a little bit about your day-to-day activities Do you teach?

Page 3154

A Yes, we -- I teach forensic fellows at Tulane, and also I teach residents, occasionally teach medical students, but primarily forensic fellows And then I also teach patients at Feliciana Forensic on various aspects of substance use So in our treatment track, I have lectures that I do once or twice a week and discuss with them, you know, issues about cocaine and how it affects them, and also about their medications and how their medications interact with the various other substances

Q Do you, besides teaching, do you treat patients?

A Yes, I do I have the forensic hospital, I'm there usually, actually three days a week I'm there more times than I'm actually at Tulane So I'm there three days a week On Wednesday is my outpatient day at Tulane, so I see outpatients during the day that both have psychiatric difficulties and substance use difficulties And on Friday we have a training session in the morning at Tulane and in the afternoon is what I set aside to review new legal cases or if the court asks me to evaluate someone

Q Have you published any papers in

Page 3155

peer-review literature?

A Yes, I have

Q And do you belong to any professional organizations?

A Yes, I do I belong to the American Medical Association I belong to the American Psychiatric Association, the American Academy of Psychiatry and the Law, the American Academy of Psychiatrists and Alcoholism and Addiction, and Louisiana -- several Louisiana societies as well

Q Are you Board-certified?

A Yes, I am

Q In what specialty?

A In psychiatry and I have an added qualification Board in forensic psychiatry

Q Can you explain to us, please, what it is that psychiatrists do What is their --

A Well, there are several major areas of various kinds of psychiatric disorders that we treat One would be depressive disorder, so people with major depressions that need either psychotropic medication or therapy Patients who have anxiety disorders or panic attacks is another group of individuals Individuals with substance use disorders, individuals that may be out of touch with

Page 3156

reality or have serious psychiatric difficulties like schizophrenia or sometimes manic depressive illness, where people have a high level of high and come down to a deep low level as well

So there are groups of patients There are others, but those are the main categories

Q Does that include also patients with substance abuse problems?

A Yes

Q Are you qualified and trained as a professional to evaluate mental and emotional conditions or states?

A Yes, that's something that I would do on a daily basis

Q Are you also trained and qualified to evaluate a person's cognitive abilities?

A Yes Cognitive just means the way the person thinks essentially, but in psychiatry it is important because we have some individuals who think very irrationally and we have to sort that out and evaluate them, and another individuals who think quite rationally and they made need some improvement So we have to sort out the person's thoughts and what's real or unreal about those and are they normal or abnormal

Page 3157

Q Are you also trained and qualified to make, to assess a person's or a patient's ability to make decisions and to make choices, is that part of what you do?

A Yes Again, that's part of the day-to-day workings, because many of the patients have difficulty making decisions and difficulty making choices And we assess that and try and help them, evaluate them in that process

Q Do you also, as part of your training and your practice, assess an individual's motivations, is that part of what you do?

A Yes One of the jobs that we are in task with at the facility is that we have to make determinations of when people go back out into society and when they are ready to We have to make determinations and provide them to the court of when a particular individual will be ready to go back into the community

Sometimes those individuals have been in the hospital for some time and they have -- may have a serious psychiatric disorder and a substance use disorder And so we have to sort those things out as are they motivated. When they get out of the hospital, are they going to be able to follow up

Page 3158

with appointments Are they going to be able to maintain the kind of things they need to in order to stay out of the hospital and function in society So that's also something I do fairly regularly

Q Can you tell us how you might get involved in a legal proceeding How does that come about?

A Usually there's one of two ways I can either be appointed by the court, which happens about half the time, that I'm appointed by the court to evaluate a particular issue It can happen -- more likely happens in various criminal issues Occasionally I'll get appointed in a civil issue where the judge is trying to sort out between two sides what's going on and they'll ask me to come in and evaluate them

And the other way is that attorneys will call me and ask me to review records and to come to some determination about a particular case

Q Doctor, does your expertise extend to decision-making human behavior and human motivation?

A Certainly Decision making, meaning behavior and those kinds of things, as well as day-to-day activities in our decisions that we have to make, both in treating patients in an outpatient setting as well as inpatients

Page 3159

Q Now, let me ask you, Doctor, what is it that you were asked to do in connection with this lawsuit?

A Well, I was asked -- Mr Wallace came to my office at Tulane about six months or so ago --

Q Mr Wallace is a lawyer with our firm?

A Lawyer with Chadbourne and Parke, David Wallace He came to my office and asked me whether or not I would be interested in reviewing some records and making some assessments about Mr Carter, about whether or not he could make knowledgeable and rational decisions throughout the course of his lifetime, whether or not he had the capacity to be able to quit smoking throughout the course of his lifetime and various issues along those lines

Q Other than within the field of human behavior and motivation or substance use, did we ask you to review any other medical literature with respect to smoking and health?

A Well, initially I wanted to take a look at what was the current --

Q I'm sorry, maybe -- did we ask you to look at any smoking and health issues other than human behavior, motivation and substance use issues?

Page 3160

A Well, the issues about whether or not an individual — why does an individual start or continue to smoke, and what's their motivation to continue to smoke and those kind of things

Q And other than that was there any other -- I mean, for example, did we ask you to assess the medical literature with respect to smoking and lung cancer, is that part of what we asked you do?

A Absolutely not I was just asked to evaluate those particular issues I did not look at the issue of causation of lung cancer or any of those kinds of things

Q How did you go about the task that you undertook? What did you do?

A Well, I reviewed Mr Carter's deposition and I reviewed his wife's deposition, Mildred I reviewed his first wife's deposition, Catherine, the depositions of his children, a brief deposition from Dr Rood, one of his treating physicians, his medical records And then also reviewed the literature on the issues that we were talking about on smoker motivation, on various aspects of smoking behavior, continuing smoking, why people continue to smoke and those kind of things

Q Doctor, are we compensating you for your

Page 3161

time spent in this case?

A Yes

Q And what is your hourly charge?

A The hourly charge for the psychiatrist at Tulane is $300 an hour

Q Is that a standard charge?

A Yes

Q How much have we -- have you been compensated so far?

A Roughly $15,000

Q Do you have an estimate for how much additional time we are going to owe you for?

A That would be roughly a similar amount

Q Based on your review of the evidence in this case, Mr Carter's medical records, the deposition testimony that you looked at and your review of the literature, do you have an opinion, Doctor, whether Mr Carter wanted to permanently quit smoking before 1991?

A Yes, it's my opinion that prior to 1991 that Mr Carter was not motivated and did not have the personal — the personalization of the risks to be able to -- or to quit prior to that. That he could have quit, but he personalized the risk at that time and quit at 1991 I think he could have

Page 3162

quit any time prior to that had he personalized the risk and been motivated to do so

Q Do you have an opinion, Doctor, whether Mr Carter's understanding of the health risks associated with smoking was in any way impaired as a result of nicotine?

A No, I didn't -- I didn't get any indication from the record that his ability to think clearly and to assess knowledge or to take in knowledge, take in information was impaired by his nicotine use by his smoking behavior

Q Doctor, I want to back up a little bit and ask you, the plaintiffs in this case are saying that Mr Carter was addicted to nicotine And I'd like to ask you what that term means scientifically, addiction?

A Addiction has -- actually has quite a broad meaning in its present interpretation It can mean anything from someone who is severely addicted to crack cocaine where they are spending all of their money using that particular drug and may be living on the street and may be dealing drugs and those kinds of things, all the way to a lay perception of having too much chocolate or wanting to eat too much chocolate or those kinds of things

Page 3163

So I think that there are many interpretations, and the interpretation has gotten quite broad

Q Is it a scientifically precise term?

A At the present time, no

Q Was there a time when it did mean something specific from a scientific and medical point of view?

A Yes, it's my opinion that in 1964 when the Surgeon General's report was written, at that time and before that, that there was a precise term and a precise differentiation between the term addiction and habituation

MR RILEY Your Honor, I have a blowup I would like to use, if that's okay

THE COURT All right

MR RILEY Your Honor, can Dr Thompson step down, please?

THE COURT Certainly

BY MR RILEY

Q Doctor, would you tell us what this is from?

A Sure, this is from the 1964 Surgeon General report, and it's page 351. And it's the definition in 1964 of those terms, the different term addiction and the term habituation So that's

Page 3164

primarily what this exhibit is
Q Where did that definition of addiction come from?
A Actually it had been used prior to that time by the World Health Organization and Dr Severs, who was a prominent doctor in psychopharmacology He was also one of the men on the advisory committee for the Surgeon General's report So he assisted in writing that and this definition comes pretty much from the papers that he has written and the World Health Organization definition at the time
So it was an accepted definition at that time around the world for both addiction and for habituation
Q Can you explain to us what the definition of drug addiction was at that point in time, Doctor?
A Yes, as -- I mean, as you can see from the top definition here, the most important thing at that time was there was a state of chronic intoxication and that was a critical thing to look at And you can see down here that this is part of the reason for it, because it was generally accepted among psychiatrists that addiction to potent drugs was based upon serious personality defects from

Page 3165

underlying either psychological conflicts or psychiatric disorders, which may be manifested in other ways if the drugs were removed So that's something that is important to look at as far as the chronic intoxication part, because as we go through time that part will be somewhat diluted
Q I'm sorry, Doctor, but why are they saying that -- what are they suggesting about why people use drugs there? What was the reason they are suggesting people used drugs at that point in time?
A Well, there is an abnormality in the way that they are functioning, so they are using the drug to escape and to try to have an altered state of consciousness or escape the present reality to be into another reality And that's primarily what that's about
Q Would you tell us what the rest of this definition means?
A Sure You can see that there is an overpowering need or desire to continue taking the drug and to obtain it by any means, and this is also an important component And the overpowering desire or need is described at other times in the report as distinctly different from the habitual need to have something on a daily basis, that they are talking

Page 3166

about a more serious disorder like heroin use or cocaine use where the individual is incapacitated in some way and may actually be involved in criminal behavior or illegal kinds of behavior
Q Is that described on the next page of the report, the discussion of the overpowering desire or need?
A Yes, it is
Q Where is that discussion?
A Okay We talked a little bit about that Compulsion exists in many grades from the habit pattern of a cigarette smoker who subconsciously reaches into his pocket for a cigarette So the cigarette smoker may do that before he realizes he has got it in his hands And that's to be clearly distinguished from those individuals who have some kind of personality defect And the personality defect plus their use of the drug may cause some kind of detriment on society by that particular use So there was a clear distinction between those two at that time
Q What's the next component of the definition of drug addiction?
A There is a psychic or psychological and generally a physical dependence on the effects of

Page 3167

the drug, so there are physical signs and symptoms that occur as well as psychological symptoms that occur in a particular individual that's addicted So there is a physical dependence, and they talk about the physical dependence in here as well
It says, proof of a physical dependence requires a demonstration of a characteristic and reproducible abstinence syndrome And that's somewhat different when you look at different kinds of substances of abuse and substances of use Okay
And -- but you need to show that this abstinence syndrome upon withdrawal of the drug or a chemical which occurs spontaneously inevitably and is not under the control of the subject So that if someone is drinking a lot, if they are drinking a six-pack of beer a day, let's say, for a while, and they go up to drinking even more than that and they stop, it's very predictable as to how they will withdraw from alcohol in a particular individual, and it's not variable Okay
And it said that neither nicotine nor tobacco comply with any of these requirements And that is because there is a lot of variability between withdrawal states both within an individual

Page 3168

or abstinence syndrome within an individual when they are smoking -- and when they smoke -- they are trying to quit from one time to another, then they have a few symptoms one time and a lot of symptoms another time And varies from individual to individual So they were making that distinction as well

And the fourth one is detrimental effect on the individual and on society And that one may apply a little bit less today, but the effect on the individual is primarily what we are talking about And it's more legal effects or the effects of using the drug to the point where someone would get into legal difficulties or problems such as that

Q Can you explain to us a little bit more about the second requirement there a tendency to increase the dose?

A The tendency to increase the dose has to do with a situation that we commonly refer to as tolerance, which has a lot of different meanings But that's where an individual needs more and more and more drug in order to become more intoxicated So, let's say, if you had someone who was using heroin, they needed $50 a day, and then as they continued to use they may build up to a habit of

Page 3169

$500 a day They may use ten times as much as what they needed to get the same level of high or the same level of intoxication as they would prior when they had -- when they were using $50 a day So that's an important distinction as well

Q Under these definitions, Doctor, can you compare, for example, how alcohol would be treated with how, let's say, caffeine would be treated?

A Okay Well, under the criteria for addiction, you would see that if a person was drinking to become intoxicated, that was their primary goal, for them to become intoxicated, and there was repeated consumption, that would fit quite well There is an overpowering desire or compulsion to continue taking It means that they take it in a way that's not normal It's abnormal

So the person was drinking and getting into difficulties with their family and other kinds of things, and that would be appropriate for that one

There is a tendency to increase the dose If someone was drinking a six-pack and then later needed to drink two in order to obtain -- acquire the intoxication or get that level of high that they wanted And there is a psychic and psychological --

Page 3170

or psychological and generally physical dependence to the effects of the drug There also is the withdrawal syndrome that you would get when you use that particular drug, as I talked about before, when you use alcohol, like I talked about before

And that's distinctly different from what you would see from caffeine On the other side where you would have caffeine, you would say that that's a habit, that you may want to drink a cup of coffee every day You may want to drink three or you may want to drink five cups of coffee every day, but that there's a desire to continue doing it, but it's not necessarily an overpowering type of compulsion There is little or no tendency to increase the dose Often people who drink coffee will maintain the same dose for a long period of time, maintain the same level of ingestion of caffeine for a long period of time

Now, there may be a psychological dependence, but the abstinence syndrome is not as well defined as one for alcohol

I think it talks a little about that in contrast to drugs of addiction, which we talked about alcohol I talked about the withdrawal, where there is a definite withdrawal of alcohol, and

Page 3171

there's not as well defined withdrawal with caffeine and other substances like nicotine

Q Was cocaine considered a drug of addiction at this time in 1964?

A Yes, I think cocaine was considered a drug of addiction at that point in 1964 In fact, in the 1800s Sigmund Freud had a friend that he thought he could get off of morphine by using cocaine But that individual ended up becoming intoxicated and dependent on the cocaine as well

So psychiatrists knew that for a long period of time

Q Is there anything in this 1964 Surgeon General's report that says cocaine is not addictive or that it wasn't considered addictive at that point in time? Is there anything that says that?

A No, I didn't see anything in the report that said that There is a forward to this portion right here that lists out all of the drugs that were possible to be placed in either category, but it doesn't say that cocaine is in one category or the other

Q Now, after 1964, did the concept of addiction change?

A Certainly

Page 3172

Q Can you please describe that for us
A Well, it -- shortly after that, there was -- the definition was expanded to include a term called dependence And that term was a broadening of the definitions and a blurring of the distinction between the drug addiction and the habituation But it didn't blur right away Originally dependence meant the same kinds of things that addiction meant And so in the 1960s, the World Health Organization and then in ICDA which is another document, the individuals were listed as dependent, but they still meant the same thing as addiction
Q Before July 1st, 1969, was there any medical group or any scientific body that said smoking was addictive?
A No
Q Before that date, was there any medical or scientific group that said smoking produced dependence or was dependence-producing?
A No
Q When was the first time the Surgeon General reached a formal conclusion that smoking was addictive?
A That was in 1988 with the Surgeon General's report that was entitled "Nicotine

Page 3173

Addiction"
Q What is it that happened between 1964 and 1988 that enabled the Surgeon General to now classify smoking as quote "addictive"? What happened?
A It was primarily an expansion of the definition Although research was going on to look at different aspects of pharmacologic properties, the main thing that happened was the definition was expanded
Q What were the -- I think we have a chart showing the criteria
A Certainly You can see here -- this is page 7 from the 1988 Surgeon General's report And we have these criteria -- this is criteria where you place the drug in a particular category, okay, or when you are just looking at the drug to try to determine does it meet criteria for a drug that you would be able to use and classify for drug dependence
The primary criteria are that it's a *highly controlled or compulsive use, that it has* psychoactive effects, and that it has drug-reinforcing behavior
Now, these criteria are much more limited

Page 3174

than the previous criteria, and they are much broader They actually encompass most of the substances that you would think of that might have any property or psychoactive effect or effect on the brain
Q For example, would caffeine fit that?
A Yeah, caffeine could fit in this category and nicotine could fit in this category And any of the other eleven or so major classes of drugs could fit in this category
Q What happened to the requirement in 1964 for chronic intoxication? Where is that in 1988?
A Chronic intoxication is not in the definition in 1988 So the definition has been expanded and watered down some Intoxication was pulled out of the addiction criteria, and we had intoxication as one set of symptoms and dependence as another set of symptoms
Now, what the Surgeon General said is that the criteria for dependence are the same things as the criteria for addiction So there was an expansion of the definition at that time to include the determine addiction in with dependence, but the intoxication part was removed so that it was very, very difficult then to discriminate between those

Page 3175

two things
Q What about the requirement we see here for physical dependence? Is that contained in the definitions that are a requirement for drug dependence in 1988?
A This is -- physical dependence, you can see right here, is one of the criteria that a dependence-producing drug may produce or often produces But it's not one of the primary criteria under the Surgeon General's report that it necessarily has to produce And that's different than from the 1964 report
Q How about this one, a tendency to increase the dose?
A Right
Q Where do we find that? I mean, that was required in 1964 Where is that in 1988?
A That was required in 1964 and, again, if you look down here, it's down on the bottom, that they often produce it, but it's not necessarily something that's required
Q *Is there a term that you prefer to use --* when you diagnose a patient, do you use the label addiction, is that the term you use?
A No, I mean, I would use it if I was doing

Page 3176

a lecture on something and I was trying to get folks to come to the lecture, I might use the term addiction, because it's a more common term and it's more attractive and flashy And so you might attract more people if you did that But normally we use dependence And we go to a diagnostic manual in psychiatry that we use that definition with

Q Are these criteria that we see here on -- what page is this? Is this page 7?

A This is page 7

Q Are those diagnostic criteria for determining whether an individual is dependent on a substance?

A No, they are not This kind of gets confusing and it sometimes even confuses me so I will try to explain that to you This is just a criteria for a drug being included So a drug is included as a psychoactive substance -- as a drug that can potentially cause dependence, just the drug itself, can that drug potentially be a part of the dependence syndrome And then we have to have other criteria if we are actually going to diagnose someone and say, You have an alcohol dependence problem, or you have a particular problem along those lines

Page 3177

Q Why do you need other criteria?

A Because these criteria primarily just give you an idea of whether the drug meets the category And the specific criteria are for diagnosing a particular patient

Q And why do you need to do that, have separate criteria to apply to a particular person? How about if we use alcohol as an example

A Okay Well, if you want, you could say that alcohol meets the criteria for a drug of dependence Okay It can be a drug, but you actually have to have a patient That patient has to be -- or an individual using the drug in a maladapted way before you can diagnose them of that and know whether you need to treat them or not So you need those criteria to diagnose them

You would have to look at specific criteria for an individual person in diagnosing them. This just tells you that the drug meets the criteria for being in the category.

But for diagnosing an individual person, if we just said, Anybody who drinks alcohol would meet this -- the criteria on here essentially, because there would be a whole host of people that might meet it. But when you go to diagnose an

Page 3178

individual person, you want to be able to discriminate who actually had the problem, how we are going to treat it and who doesn't So that's why we use the other criteria

Q Where does the Surgeon General's report -- does it refer to the diagnostic criteria for an individual?

A Yes, it does I believe it's 249, halfway in the book

Q What does it refer to?

A It refers to the DSM-III-R which is a statistical manual for diagnosing individuals that was used at that time And that -- those are -- those criteria are used if you are going to diagnose an individual

So if you wanted to diagnose a particular patient, you can use guidelines that are in the Surgeon General's report, but you would use criteria that are outlined here from the DSM-III-R And that's what they used at the time to place in the Surgeon General's report

Q Well, Dr Feingold told us that these criteria are the same as the diagnostic criteria Is that right or that is wrong?

MR WILNER Object to the form That's

Page 3179

not what he said Object to the preamble

THE COURT Sustained

BY MR RILEY

Q Let me ask you this, are there differences between the criteria for drug dependence and the criteria for diagnosing an individual?

A Yes, there are differences between those two

Q Are these the criteria for diagnosing an individual?

A Yes, those are These are criteria, generic criteria for diagnosing someone with a substance dependence disorder

Now, you have to apply each individual drug into that particular -- into those criteria if you want to diagnose an individual patient And there are extra pieces to the puzzle that come in as you go along. We'll try and make that -- I'll try and make that as clear as I can

Q Are these criteria used for all substances under the DSM?

A Yes, they are Under the DSM-IV, they are used for all substances

Q So that would be heroin or caffeine?

A Yes

Page 3180

Q How would you -- if you were going to diagnose a person to see whether they were dependent on alcohol, let's say, how would you go about doing that?

A Well, I think it's important to take a look at the subparagraph right under the criteria First of all, you want a maladapted pattern of substance use and that's important The person has to be using it in a way that's not an adaptive mechanism for them Let's say that you wanted to go home at night and just have a beer at nighttime to help you relax and go to sleep or help you relax while you're watching TV or whatever That might be an adaptive pattern for someone to go home and use the substance But if someone went home every night and drank a six-pack or two six-packs, passed out, couldn't go to work the next morning, that would be a maladaptive way of using it

So it's important that you get that as a baseline And then it has to lead to some clinically significant distress or impairment in the individual And that can be manifested by three of the following symptoms

Q What does that mean, clinically significant impairment or distress? What does that

Page 3181

mean?

A Well, you can look at it -- you know, you could say that maybe it means a person who would actually come in for some treatment as clinically significant I think it's -- does the clinician assess what they're seeing as something that they need to treat or something that they need to deal with

Q Is there a term called diagnostic discriminability?

A Yes

Q What does that term mean? Explain that

A What it basically means is that you want to be able to pick out people who have a problem that you can treat and weed out the folks that don't have a problem, that you don't necessarily have to treat And that's the -- an easy way of saying it

Q If, for example, we -- these criteria for substance dependence were applied to people who drink alcohol, what percentage of them would be diagnosed as dependent on alcohol?

A Well, I think if you just took the population at large of Americans at large, you would probably find that maybe eight percent or so of people in America have significant problems using

Page 3182

alcohol where they would meet this criteria for substance dependence, if we went through the whole thing

Q And how about if we tried to take these criteria and applied it to people who smoked cigarettes What percentage of people would fit these criteria then?

A Well, it really depends on how you interpret the criteria If you interpret them fairly strictly, you might have no one in the group If you interpret them fairly liberally, you might have the whole population But you don't necessarily sort out those people that have the most significant problems or the ones that have the least significant problems

Q Is that a satisfactory level of diagnostic discriminability, Doctor, from your point of view as a clinician?

A Not in my opinion You can tell a person either smokes or doesn't smoke by asking them So it doesn't give you the diagnostic discriminability that you would with other substances

Q Can you explain to us how the first criteria here, tolerance, would be applied to alcohol, let's say?

Page 3183

A Yes Again, there is a need for a markedly increased amount of the substance to achieve intoxication and/or the desired effect that the person wants We saw that from -- it was the descendant from the '64 report in those earlier definitions, that the person uses, again, if you had three beers and you needed six in order to get the same level of intoxication over time

And then B is essentially the flip of A, markedly diminished effects with continued use of the same substance So you would use over a period of time and not get the same desired effect So if you were used to drinking three beers at nighttime, and then after a while you weren't feeling less anxious or feeling comfortable after you did that

Q And what are the -- what are the symptoms of withdrawal from alcohol?

A The symptoms of withdrawal from alcohol actually are specified in another area, and we can go through those if you would like

Each category of withdrawal has a -- some separate criteria And so we have to look at those and try and point some of these out Now, you

Have -- with the withdrawal criteria, you have cessation or reduction in alcohol that's been

Page 3184

heavy and prolonged And then you have two or more of the following developments

And when I -- when you see patients come into the hospital and they are having withdrawal symptoms from alcohol, they can either have sweating or high pulse rate or they can have increased hand tremor It's a very course tremor that's pretty easy to see and the doctors can recognize And they have insomnia or difficulty sleeping Sometimes they have nausea and vomiting in the process They may proceed to -- what's called delirium tremens, where they actually see things that are not there or hear things that are not there in the process of withdrawing And that's something that can be fatal if not treated So ten percent of people have delirium tremens and if it's not treated can die from that

And psychomotor agitation is another thing that you see The person may be hyped up while they are shaking Anxiety and grand mal seizures can also occur in the process And that's a seizure where the person falls on the ground and their arms and legs are shaking, that kind of thing

Now, in the symptoms from Criteria B have to cause, again, clinically significant distress

Page 3185

issue or there is an impairment in the way they function at home or they work or other important areas of their functioning And then you have to try and rule out any kind of medical disorders

So if you thought there was a medical disorder, I might ask, you know, one of my internal medicine doctors to come over and take a look at the person and check out their liver or whatever I thought might be affected by the alcohol use

And that's primarily the alcohol criteria Now those have a -- they usually have a reasonably predictable course So that you can give someone -- someone will have those symptoms each time they withdraw from alcohol If they are using the same amount and it's the same individual, you can usually tell when they are going to have a severe withdrawal or not

So one of the ways to check that out is to go back in the records and look and see the last time this happened, did they progress to have seizures or did they progress to have delirium tremens

And that's what the Surgeon General's report in '64 was also investigating, because the withdrawal symptoms were very predictable in their

Page 3186

presentation

Q So that's this Category 2 here?

A Right And that's the characteristics -- these are the characteristic withdrawal symptoms for alcohol withdrawal And then you can also have the same substances taken to relieve or avoid withdrawal symptoms That can occur with many different kinds of substances

Q What's the next category, taken in larger amounts? What does that mean?

A Well, the substance is often taken in larger amounts or for a longer period of time than was intended We all know of friends or family members that we may go to a party with them together and everybody at the party has one drink, and then they seem to have one drink and they go to six or seven And they can't seem to control that Every time they go to a function, the same thing happens I think that's commonly what we see in alcohol

Then we have four, there is a persistent desire, unsuccessful efforts to cut down or control substance use An example of that would be someone going into a program in order to try and discontinue their use, and then shortly thereafter they would be back to using the same level that they were using

Page 3187

before

Okay There is a great deal of time spent in activities necessary to obtain the substance, i e , visiting multiple doctors or driving long distances That would apply to someone who has used prescription medications And they also have chain-smoking in there And an individual with alcohol might be waking up in the middle of the night with, you know, having shakes or whatever and go to the liquor store and pick up alcohol and consume it in order to avoid having those symptoms

But an important social or occupational, recreational activities is the next one And what that is, is when someone is actually using a substance and can't attend an activity If they are in the process of going out to dinner or whatever with their wife and prior to even leaving the house they become so intoxicated that they pass out and can't go or they miss important functions that have happened in their family, missed the son's graduation because of substance use And that's primarily where that one fits

And then the substance use is continued despite the knowledge of having persistent or recurrent physical or psychological problems They

Page 3188

are likely to have been caused or exacerbated by the substance or made worse by the substance
And those kind of things we can see in a lot of different disorders, but you can see that in alcohol surely
Q Now, you told us that these criteria do not distinguish well -- or don't really distinguish very much between smokers who may be dependent and smokers who may not Can you explain to us why that is?
A Sure If you -- I mean, if you interpret the criteria in a way that you would think about other substance use disorders like alcohol or whatever, they don't apply to smoking as well So that if you tried to apply them in that way, you would actually have a difficult time putting someone in If you used ancillary pages from the DSM-IV and plugged smoking in a way where it will fit, you may have all smokers in there So it really eliminates that ability to discriminate between the two
Q So criteria are applied that broadly such that you capture everybody or everybody would be lumped in as dependent on that particular substance, whether it's smoking or anything else Is there any real scientific discriminability in those -- in the

Page 3189

diagnosis itself?
A Well, no As I said before, you would get all of the smokers or you'd hardly get any smokers
Q Well, Doctor, what I would like to do, maybe we could go through these criteria, and you could tell us whether -- how they would be applied to a smoker or Mr Carter in particular Why don't you start from the top
A Sure Tolerance, remember before we talked about tolerance
Q Why don't we -- if you would, why don't we start with the maladaptive pattern of substance abuse.
A Well, you have a maladaptive pattern of substance use You know, in my review of the records, I think that Mr Carter used cigarettes in a way that everyone else uses them, or he used them in a similar fashion as other people use them They start and gradually move up to a certain level, and they maintain that level for a long period of time
So I don't see this as necessarily a maladaptive pattern I wouldn't want to classify everybody who smokes as having a maladaptation or not being able to adapt appropriately from a psychiatrist's standpoint

Page 3190

And then leading to clinically significant impairment or distress as well I mean, you know, the majority of smokers who smoke, smoke in a certain pattern And that's a reasonable pattern, and they are not having maladaptive ways of functioning
Tolerance is one that's defined by a markedly increased amount of the substance or a markedly diminished effects of use of the same amount Now, Mr Carter over time, you could say that when he first started smoking and he smoked, you know, the first couple of cigarettes and got dizzy, and then smoked more cigarettes and wasn't dizzy, you know, maybe he might fit in that But I don't see that he needs a markedly increased amount of it over time to achieve an intoxication, which is a holdover from the '64 report
Now -- and there is a markedly diminished effect of continued use I think he pretty much had the same effect over the course of his lifetime of smoking
Q You mentioned when he first started smoking he didn't smoke as much Is that tolerance in the traditional classic sense of the word or is there a different term for that?

Page 3191

A Well, I would try to classify that as toleration or being able to tolerate the initial feelings of dizziness or the initial feeling of nausea, and then -- but rather than a classic kind of tolerance where you would see someone with a serious substance use problem becoming more and more intoxicated and needing more and more to get intoxicated
Q Does Mr Carter fit the -- meet the first requirement there, tolerance?
A Not -- I mean, I would -- I interpret those things fairly strictly dealing with these things, and I would have a hard time putting him in there So I don't see him fitting in that particular category as far as having significant tolerance
Q What about withdrawal? We have to refer somewhere else?
A Yeah, we have to refer to another similar diagnostic criteria for withdrawal You have the alcohol in here and nicotine
THE COURT Let's stand up and stretch
(Brief recess)
BY MR RILEY
Q What are these, the diagnostic DSM-IV?

Page 3192

A You have daily use of nicotine for at least several weeks, an abrupt discontinuation of the use or reduction in the amount of nicotine causes four of these symptoms here There's eight symptoms and it causes four of those

Now, you can see that these symptoms are much more subjective symptoms in which you would have in the symptoms for alcohol, meaning that they are a lot more subject to interpretation from individual to individual And they can't be as readily measured as these other kinds of symptoms like from alcohol withdrawal or from opiate withdrawal

The person has a sad mood They can't sleep, irritable, frustration or anger, anxiety, difficulty concentrating, restlessness, a decreased heart rate and increased appetite or weight gain

Now, this was recognized in the '64 report and many of these symptoms were in the '64 report And they talked about nicotine not being an addiction but being a habit And it said that you can have symptoms that are similar to this, however, they don't incapacitate you and they are not as predictable as the ones with other substances of abuse or use

Page 3193

The symptoms in this Criteria B have to cause clinically significant distress or impairment in social and occupational functions or important -- other important areas And you have to rule out a medical disorder as well that may be causing the symptoms

Q Did Mr Carter exhibit some of these symptoms?

A Well, I think the difficulty is distinguishing between a symptom someone is actually exhibiting and a person's frustration or anger in dealing with the difficult situation

I think when he quit in 1983 there was a lot of pressure for him to quit, particularly pressure that he was feeling from his wife, in that he may have well have been angry about that and frustrated about that process as well as the process of going through some kind of reduction of nicotine level in his system

So it's hard to differentiate between how much of that is something that he's feeling because he does not have nicotine in his system anymore and how much of that is feeling because he has a well-liked reinforcer, i e , when he reports that smoking was his best friend and that was

Page 3194

corroborated and he looks at that as a feeling of frustration and anger about that

And there is a question, I think anyway, of whether he really wanted to quit at that time Where he was feeling that pressure to quit, and I'm not sure that he was as motivated to quit And may have been feeling some of these symptoms because of that rather than just from withdrawing from nicotine

MR WILNER Excuse me, Your Honor, just in line with what we had done with Dr Feingold, I would appreciate -- the question was, did he have any of those symptoms? When I listened, I didn't ever hear a yes or no or I don't know but a long narrative answer We would just ask that perhaps if we had a yes or no or I don't know, and then an explanation, we would be following the same rules we did for Dr Feingold, at least tried to

THE COURT Mr Riley

BY MR RILEY

Q Doctor, are you able to state whether Mr Carter had these symptoms?

A I don't know that he actually met -- I would say no, I don't know that he met four of these at any one time that could be differentiated from

Page 3195

normal frustration

Q Now, did he meet Subpart C?

A Well, you know, there is some -- there was some testimony about not going to work for that week, and -- but I think there was also concern that it obviously wasn't clinically significant for him He didn't call the clinic back He didn't return the phone calls And I think that that's an important thing that we need to look at as well

So I don't know that it would meet those criteria if you went about interpreting it fairly strictly

Q Well, how about these other criteria? Did Mr Carter meet the third criteria?

A Okay Again, if you interpret these strictly and look at issues of other substances, I don't see that it was taken in longer time, larger amounts or over a longer period of time than he intended From my review of the records, I feel that he smoked for as long as he wanted to smoke And he quit in 1991 when he was motivated And the risk was personalized to him when he coughed up blood I think that's when he wanted to quit and was motivated to do so

So I don't see him meeting that criteria,

Page 3196

their persistent desire, unsuccessful efforts to cut down and control -- we talked about that

A great deal of time is spent in activities necessary to obtain the substance I didn't see any testimony either in the record or in his deposition that he was chain-smoking, which he may have met that criteria

And then important social and occupational or recreational activities given up due to the actual use of smoking cigarettes So that he did not go somewhere because he smoked cigarettes and he became too intoxicated or he smoked cigarettes and got ill or something like that, I didn't see that in the record

The final thing, I think he probably would meet that even if you had a conservative view of this, and that's because he has had a medical disorder He had a persistent cough he was aware that was related to his smoking and he continued to use But I don't see that he meets three criteria or that he meets a classic definition of a substance use disorder by his cigarette smoking

Q So is it your opinion looking at all of these criteria, would you render a diagnosis whether Mr Carter was dependent or not on nicotine?

Page 3197

A I certainly wouldn't say that he was dependent on nicotine In my opinion and by the '64 criteria, which I think is much more clear delineation, I would say that he was in the habitual category rather than in the addicted category

Q I wanted to ask you, if you would, to just -- if we could compare -- and I'm sorry to go back over this, but can you compare the withdrawal symptoms that are associated with nicotine, let's say, to those that are associated with alcohol?

A Okay Well, we went -- I think we went over that And these symptoms can vary between one individual, depending on whether or not they are experiencing stress or not in the course of their lifetime So at one point in time when someone attempts to quit they meet a lot of these criteria At another time they may meet hardly any

If a person has a positive framework and positive attitude about attempting to stop smoking, they'll have less of these symptoms than if they have a negative attitude or negative framework about it If they are in a less stressful environment as well

So they fluctuate much more than the symptoms that we would see with other kinds of drugs

Page 3198

that were traditionally addicting

Q You said that they were more variable Are they also more subjective?

A Yes And they are more subjective because they are not as easily measured, where you can measure the blood pressure, the pulse rate, see a person shaking if they have an alcohol dependence problem

Q Can you tell us -- Doctor, I think you can resume your seat

Can you tell us whether these criteria for substance dependence, whether they have anything to do with predicting whether somebody will quit smoking or not?

A No, I do not think that you can predict whether someone will quit smoking by evaluating whether they meet these criteria or not

Q If a person is diagnosed as nicotine dependent, does that mean they are more or less likely to quit than somebody who is not?

A No, it does not in my opinion

Q Is there any relationship between the amount of cigarettes somebody smokes and whether that person is likely to quit or not?

A No If you look at long-term studies of

Page 3199

long-term relapse, you do not see a significant difference in individuals with a number of cigarettes they've smoked and their ability to quit

Q How about the length of time that the person has been smoking, does that predict whether they are likely to quit or not?

A Not long-term, it does not

Q Is there a relationship between the severity of the withdrawal symptoms that a smoker reports and whether that person is likely to quit smoking or not?

A No, there is no correlation or there's not a significant correlation between those two things

Q If a smoker reports more -- or smokers who report more severe withdrawal symptoms, are they any more or less likely to quit smoking than those who report symptoms that are less severe?

A The studies have not shown that to be true

Q Is there a relationship between the use of Nicorette gum or nicotine gum in whether a person is likely to quit smoking or not?

A There doesn't appear to be a long-term relationship between the use of Nicorette gum and a person's ability to quit

Page 3200

Q There has been testimony in this case that Mr. Carter is addicted to nicotine because he still uses nicotine gum Now, do you --

MR WILNER Excuse me, Your Honor, we don't mind that being asked as a hypothetical, but it misstates the evidence in the case if it's asked as an assumption -- or rather if it's not asked as an assumption

MR RILEY I'll rephrase it, Your Honor.

THE COURT All right

BY MR RILEY

Q Does the fact that Mr Carter still chews nicotine gum, does that mean that he's still addicted to nicotine or that he ever was addicted to nicotine?

A Well, he, right now, from the deposition records I've read and the trial court testimony, he chews three quarters of a piece of Nicorette gum per day, sometimes a whole piece He cuts it up in four pieces, and that is roughly equivalent to a cigarette, if you think about it that way

So he's taking a couple of puffs at morning, noon and evening at the max But he's also -- drinks it with coffee I mean, he takes it with coffee He takes it with food And those --

Page 3201

when you take the gum with food or with coffee, it diminishes the amount of nicotine that goes into the system

So I think that most of the benefit that he is getting presently from the use of the gum is that it reminds him that he used to smoke And I believe he even said so in his testimony that it reminds him or makes him aware that he used to smoke and it helps trigger him There is a psychological benefit that he's getting from it but I certainly don't see that he's getting a major physiologic benefit from it that would equal anywhere near the amount of his normal smoking a pack and a half a day

Q You mentioned the fact that he took it with coffee and after meals Does that affect how the nicotine is absorbed?

A Yes, because it's absorbed in the mouth and that changes the way the nicotine can be absorbed So there is less nicotine absorbed when you're drinking coffee or right after you're eating

Q Mr Carter told us, though, that he -- in his deposition anyway, he said that he craves the gum And yet you say that doesn't mean he's

Page 3202

addicted How do you explain that?

A Well, a craving is a very subjective symptom I mean, it was used in the DSM-III-R manual, and now it's not used as one of the criteria in the DSM-IV because it is quite variable from individual to individual

A craving may be described as an urge And we have lots of different urges to do many different things So you may have an urge to have a glass of milk and cookies at nighttime or an urge to do whatever But those kinds of cravings are difficult to quantify

Q Doctor, you've told us that the amount somebody smokes doesn't predict whether they'll quit You've told us the length of time they have been smoking doesn't predict whether they'll quit You've told us that whether they have symptoms or they report withdrawal symptoms doesn't predict whether they are going to quit smoking or not What is it that predicts or that does predict whether a smoker will quit smoking?

A Well, I think the primary factor is, is a person motivated to quit smoking? Does that person personalize whatever risk they perceive, and are they motivated enough to quit at that time? So it's

Page 3203

a combination of them being motivated and personalizing their risks so that they can go ahead and follow through with that

Q Do you have an opinion based upon a reasonable degree of medical probability whether Mr Carter was truly motivated to quit prior to 1991?

A I don't see that he was truly motivated to quit prior to that time I think he was motivated to quit in 1991

Q Why do you say -- what lets you to conclude that he was not motivated to quit prior to 1991?

A Well, prior to 1991, there were many people who were trying to encourage him to quit, and I think reasonably so His family members were concerned about him, and some of his friends were concerned about him. And they were attempting to get him to quit, and he was using various methods to try to quit

But eventually you have to put the cigarettes down and not pick them back up again And you have to be motivated to be able to do that

I think the time frame of him -- he was smoking for 44 years over 300 days per year, smoking

Page 3204

on a daily basis The number of days that he spent actually not smoking cigarettes is less than a couple of weeks.

So I don't see that he was motivated and persistently trying to find ways to quit smoking I think the family members were encouraging him to do so He was becoming aware of the health risks and was aware of them throughout his life

But I'm not sure that he had the motivation until in 1991 he coughed up blood And when he saw it, he quit And he knew he was going to quit when he coughed up the blood and saw it He knew there was something wrong, and there was something seriously wrong

Prior to that time, I think he thought maybe it would never happen to him He would never experience any of the physical problems associated with smoking

Q Was the risk -- Mr Carter was certainly aware that there were risks associated with smoking Did those risks, the fact that there were risks, health risks attached to smoking, did those risks motivate Mr Carter to quit?

MR WILNER Object to the preamble as to what Mr Carter was aware, unless he's asking in the

Page 3205

form of a hypothetical

THE COURT Sustained

BY MR RILEY

Q Assume that Mr Carter had been advised by family members that smoking was bad for his health Assume that he was advised by his physician that smoking was bad for his health and he ought to quit to reduce his risk of lung cancer, stroke and heart disease Assume that he saw public service announcements on TV advising that smoking might cause lung cancer Assume that he read that in the papers that smoking was associated with cancer and emphysema and other illnesses Was the knowledge of those risks, did that motivate Mr Carter to quit smoking?

A No, they did not

Q And why not?

A Well, I mean, I think that he reported that -- and it's common for us to put things back into the future When we're dealing with things in the here and now, and we're trying to make decisions right now it's easy for everybody to put things off and not do them When you enjoy doing something and something is pleasurable for you, you can -- it's easier to say, Okay, I'll do that Okay, I'll smoke

Page 3206

that cigarette, then I'm going to stop so that there is a probability or a possibility that I won't have any health risks over the course of my lifetime

So I think it's much easier for him to do that It's much easier for any of us to do that if we are trying to do something -- just trying to loose ten pounds or whatever You can think you're wanting to do that at the same time you are eating a bowl of ice cream And saying, Well, maybe I'll stop tomorrow Maybe I'll do those things

So that's -- I think that's a common thing many folks experience

Q Do you have an opinion to a reasonable degree of medical probability whether a warning from The American Tobacco Company prior to July 1, 1969, would have persuaded Mr Carter to quit smoking?

MR WILNER Object, vague as to what kind of warning

THE COURT Overruled

BY MR RILEY

Q You can answer, Doctor

A Okay It's my opinion at that point in his life, he was a young man, and I don't think he was even thinking of the long-term -- you know, putting that as a top priority I think that you

Page 3207

could have warned him in any way that you wanted to prior to the time that you just discussed and he would have still said, Well, I'm going to be, you know, I'm going to be one of the two out of three I'm not going to be the one that this happens to I'm going to be the lucky guy in this process It's not going to happen to me

Q Are you aware of evidence from Mr Carter's deposition and from his trial testimony that he was aware of health risks associated with smoking?

A Yes I think that he was definitely aware, that he had a general knowledge of what health risks were available, and he had very specific knowledge of what health risks were available

Q And what was his attitude about that information about smoking and health? What was his attitude towards it?

A Well, I think his attitude was that, you know, he was a confident man and he is a confident man He is used to making very important decisions and making them fairly frequently I think when he makes up his mind to do something he is someone who will probably follow through with that and carry on

Page 3208

with it
And when other people are coming up to him and saying here's information about why you should stop and whatever, there are many times in the record where he just didn't want to review that or he didn't want to look at it
Q Do remember when he said something about I've got to quit smoking or quit reading? Did you read that in his deposition testimony?
A Yes, I did
Q What does that suggest to you about his motivation and his willingness to respond to warnings about cigarette smoking?
A Well, I think it demonstrates that he is aware, that he knows these risks, but yet he's not ready to act on them He's saying, you know, I don't want to read about it
In his wife Mildred's deposition she would put — in her deposition and the trial testimony, I think she talked about putting newspapers and articles and things for him to read But he didn't want to deal with that or he didn't want to address those issues
His son brought it up many times that he should quit for, you know, the health risks when he

Page 3209

was in chiropractic school And I think the children -- in their depositions, there was the idea that we didn't, you know, really talk to Dad about that or bug him a whole lot about that when we were younger, because we knew that he wanted to smoke
Q You mentioned the fact that Mr Carter thought it wouldn't happen to him Is there a psychological term for that?
A Certainly And it's not an abnormal thing It's something that we do all the time It's our ability to rationalize away risk and not think about risk in the here and now
If, you know, if I wanted to ride a motorcycle as Mr Carter liked to ride motorcycles, maybe he would say, well, I'll ride it on the back roads and then I won't have to worry about traffic I'll do something to make it a little safer even though I know it's a risky behavior
It's a way of us rationalizing things that we do every day When you wake up in the morning, you have a list of eight or ten things you have to do that day The things that you like to do are going to come to the front of the list The things you don't like to do will go to the back of the list Usually you will have some kind of reason as

Page 3210

to why you want the ones that come to the front Even though the ones on the back of the list may be ones you really need to get accomplished
So we can all rationalize our behavior in one way or another
Q Was his attitude the results of any cognitive impairment?
A No, I don't think that he was in any way impaired or unable to be able to think clearly, to be able to assess the information that was available to him, to be able to act on that information He was -- he had -- obviously he functioned well at his job He was promoted from a GS-6 to a GS-15 He was able to accomplish many things at work So I don't think that he was cognitively impaired in any way that he could not make that decision
Q Was his attitude the result of addiction or dependence on nicotine? His attitude that it wouldn't happen to him, was that the result of nicotine addiction or dependence on nicotine?
A No, I don't see that nicotine impairs someone's ability to be able to think I mean, if that were true then we would have to say that we have you know, 50 million irrational thinkers in the United States You know, that a quarter of the

Page 3211

population is not thinking rationally Many people think rationally and perform high-level jobs while they're smoking cigarettes
Q Was Mr Carter's decision to smoke cigarettes, notwithstanding his knowledge that there might be some risks involved, was that consistent with other decisions he made in his life?
A Certainly There were other things that he made decisions about where there was particular risk involved He flew airplanes That's not something I would be particularly interested in, because for me that's too risky I wouldn't do that Other people might not
He rode motorcycles, even though he was -- that both of his sons had had -- one had had an accident with a motorcycle and another one had got cut off and didn't ride motorcycles anymore But he was able to ride and to rationalize that that was an okay thing for him to do because of the way he was doing it
So I think there are other areas that he was able to look at risk as well With his -- in the area of his diet, the doctors had told him several times that he needed to adjust his diet because of his cholesterol level And yet he hasn't

Page 3212

been able to comply with that and to adjust his diet in a way that would comply with his cholesterol level or allow his cholesterol level to come down

So I think there are many areas other than just smoking where he was able to rationalize away things and not be motivated, but it didn't mean that he doesn't have the capacity to accomplish it

Q Now, there is a claim in this case that Mr Carter wouldn't have smoked if he had been given a warning from American Tobacco Company back in the 1940s And I'd like to ask you whether you have an opinion to a reasonable degree of medical probability whether a warning back then would have deterred Mr Carter from smoking cigarettes? Do you have an opinion on that matter?

A Well, I think that young men tend to feel particularly not very vulnerable to risks So I don't think that he would have adjusted his thought process at that time when he was feeling -- he was young and feeling nonvulnerable to have a warning at that point in time and change his behavior I mean, that's -- if you look at, you know, young men in general, they tend to think, well, they do more risky behaviors They say, Well, it's not going to happen to me, because, you know, I'm physically

Page 3213

fit I'm capable of handling these things And they push that back even farther

So I don't think it would have made a major difference in his decision-making process

Q What's the impact of a risk that's 30 or 40 years in the future on a 20-year-old?

A Well, I don't think it you know, that it makes a big difference in the way that person is going to change their habits Many young people even today, when we have lots of information out there, young people are smoking cigarettes now and starting to smoke And it's unfortunate, but that information is out there And there is a lot of information available for people to review now

Q There has been some suggestion in the case that deciding to smoke cigarettes is like getting on an airplane that has a 1-in-3 chance of crashing And I'd like to ask you whether that's an appropriate analogy in terms of the decision Mr Carter faced with respect to his smoking cigarettes? Is that an appropriate analogy, Doctor, in your opinion?

A I wouldn't think so If you're doing a behavior over the course of 30 years or 40 years, and each year you say, Well, the risk of crashing --

Page 3214

you fly a plane every day for 30 or 40 years, and you say each year the risk is going to increase a little bit that if you get on those planes and you fly them that you might be involved in a crash

I mean, we all think about that when we fly on regular airlines The more you fly, the more likely you are to being involved in a crash But at some point in time you can say, I don't want to fly planes anymore You can stop at five years You can stop at ten years And then your risk diminishes from that time on if you're not flying anymore Or you can fly less frequently and the same thing

Q Well, is smoking an irrevocable decision in your opinion?

A It's one of those -- it's one of those decisions that if you make the stop, there are benefits from stopping

Q There's also been some suggestion, Doctor, in this case about providing a package insert Have you taken a look at that insert that the plaintiffs have proposed?

A Yes, I have I don't think I have it readily available

Q Did Mr Carter receive -- (tendering

Page 3215

document)

A Okay

Q Did Mr Carter receive warnings about cigarette smoking in your opinion that were more compelling or more personal or more direct than that package insert?

MR WILNER Object, vague as to time

THE COURT Time frame?

BY MR RILEY

Q Doctor, at any point in time, did Mr Carter receive warnings that were more compelling and direct and personal than the package insert?

A Yes, I believe that he received warnings from family members and from friends that they were concerned about his health and that they wanted to see him discontinuing smoking And those warnings are much more personal I think that warnings for young people that would be couched along these lines would not necessarily get a great response

I mean, young people want to know, Are your teeth going to turn yellow? Is your breath going to stink? Are you less likely to be able to engage with your significant other and have a relationship with them? Those kinds of things are

Page 3216

much more attractive for young men and young women that are considering whether or not to smoke than, you know, this kind of a pamphlet with skull and crossbones on it.

Q We've heard testimony about the effect of nicotine on the brain in this case And I'd like to ask you whether nicotine prevents a person from making a decision to smoke or to quit smoking?

A No, there obviously are effects of nicotine on the brain And -- but certainly that doesn't incapacitate a person to be able to make a decision to stop if they are motivated and if they've personalized the risks to stop

As I said before, I don't think that it incapacitates a person's ability to have the will to stop

Q Doctor, I would like to turn your attention to a somewhat different issue, which is some testimony that has been provided in the case that there was research conducted on the pharmacologic effects of nicotine by a laboratory in Switzerland Are you aware of that research?

A Yes

Q And you have looked at that?

A Yes

Page 3217

Q And what type of research was done at the Swiss laboratory?

A Well, I mean, without getting -- trying to get too complicated It was looking at nicotine's effects on the brain One area was looking at issues of release of a hormone called ACTH which is released in the brain and can modulate certain kinds of functions within the body

And another one was looking at whether nicotine increased or decreased one of the chemicals in the brain in relation to another tranquilizer called reserpine And those two studies and several others were in there But a lot of it didn't have to do with the effects of nicotine on the brain Those two did

Q Well, that research, if it had been provided to the Surgeon General's advisory committee back in 1962 and 1963, would it have provided the committee with information about nicotine that wasn't already available?

A The information, some similar information was actually available to the committee, and those studies and interest in the effects of nicotine on the brain were being studied by some of the individuals who were mentioned in the bibliography

Page 3218

But I think the main thing is that unless these studies demonstrated that nicotine causes some kind of intoxication that they would not had have had a major influence on the way these scientists were looking at the issue, because just the definition -- at the time they wanted to have intoxication be a part of the drugs of addiction And nicotine was not demonstrating that it was intoxicating

And so I don't see how that would have made major changes in the way they looked at the report

Q Was there anything in that research, the Swiss research, that suggested that nicotine was intoxicating?

A No, I didn't see anything that said it was intoxicating

Q Is there anything in any of the medical research you've seen as you sit here today that suggests that nicotine is intoxicating?

A No, I think that you get a little light-headed the first time you start smoking, but as far as being intoxicating, a normal user that uses -- or the normal smoker that smokes on a daily basis and smokes a pack a day, that you certainly

Page 3219

don't -- wouldn't say that a quarter of the population is running around intoxicated all the time I wouldn't be able to say that

Q If the 1964 definition of addiction were still applied today, even taking into account the results of the Swiss research, would smoking be classified as an addiction or as a habit, if we applied the 1964 definition?

A Right, I think it would still be applied as a habit because of the intoxication aspect of it That there isn't that level of intoxication that those individuals required in putting that definition together

Q Now, there's also been some testimony in this case about some papers by some doctors by the name of Johnston and Head Are you familiar with those papers?

A Yes.

Q And would you tell the jury what those papers are about?

A Well, Dr. Head basically had chronicled his own use of tobacco And in his report, he talked about what happened to him when he started smoking And then when he stopped smoking the effects that he had And then when he would start

Page 3220

back up smoking again
And the other report by Dr Johnston was a report where he actually self-administered or injected himself with cocaine and also injected himself with nicotine and felt that there were similar effects between those two drugs
But the Surgeon General's report, when they came up with the report, they considered those Those are in the bibliography of the report
Q Those two papers are cited in this document, the 1964 report?
A Yes They are in -- before I guess at a page, let me just take a look
MR RILEY May I, Your Honor?
THE COURT Yes, sir
A Page 357, I believe, is where it's located in Cite No 12, is Head And Cite No 13, is Johnston
Q So both of those papers were known to the Surgeon General's advisory committee back in 1964 when they issued their report?
A Yes, they were
Q And those papers compelled the conclusion that smoking was addictive or were they consistent with the conclusion that smoking was a habit?

Page 3221

A Well, they reviewed those papers and came to the conclusions that they came to So they were -- I'm sure with the totality of the literature that they determined that smoking was a habit, and they determined that other drugs were addicting
Q So even though they knew about those papers, they concluded that smoking was a habit?
A Yes
Q May I have a moment, Your Honor?
THE COURT Yes, sir
MR RILEY Could we have a recess, Your Honor?
THE COURT Until 4 15, would that be sufficient, or do you need more time?
MR RILEY 4 20?
THE COURT We'll be in recess until 4 20
THE BAILIFF All rise, this court is recessed until 4 20 by this clock
(Change of reporters at 4 10 p m)

Page 3222

THE COURT Mr Riley
MR RILEY Your Honor, I have a few more questions.
THE COURT All right
Mr Forte, would you bring the jury in, please
THE BAILIFF Yes, sir
(Jury present)
THE COURT Please be seated
Mr Riley
MR RILEY May I, Your Honor?
THE COURT Yes, sir
DIRECT EXAMINATION (Continued)
BY MR RILEY
Q Doctor, there's been some talk in this case about relapse rates when smokers quit and then they return to smoking Are you aware of studies that address relapse rates among dieters?
A Yes
Q Studies that address that?
A Yes
Q And what do those studies show?
A That the relapse rate among dieters is quite high as well So that -- individuals who are trying to comply with a diet or lose a certain

Page 3223

number of pounds may have difficulty and the majority of them often have trouble losing that weight and then may actually gain back if they lose So it can be just as difficult
Q Why do dieters relapse?
A Well, I think probably the same, the same reasons that smokers relapse And that is that your long-term goal or long-term benefit is much harder to accomplish than a short-term benefit So it's hard to say, well, I'm not going to treat myself to this pleasurable activity now and put it off for a benefit later And I think that's the same, the same kinds of things that you see
Q Are you aware, Doctor, of controlled studies that compare people who quit smoking on their own to people who quit smoking in clinics?
A Yes
Q And what does that research show?
A Well, it shows that individuals who quit on their own -- that the vast majority of people do quit on their own And individuals -- and only a small percentage of individuals actually are able to stop by going to a clinic That's not to say that both of those methods should not be used,

Page 3224

but it's -- the vast majority of people who do stop smoking stop smoking on their own
Q Why is that?
A Well, I think that, again, it has to do with when an individual is motivated enough and personalizes whatever risks they perceive for a particular behavior that they can change that behavior And even though they may be smoking a lot of cigarettes or less cigarettes or, you know, and dieting issues as well, someone is motivated to go for it and do what they need to do, then they can
Q Is quitting smoking like quitting heroin or is there a difference?
A Well, yeah I think there is a significant difference between those two And the primary problem with that is that when you are intoxicated from a particular drug, it impairs your ability to think clearly and to think rationally
The person who may be using heroin may be thinking irrationally Their cognitive abilities, their abilities to think about is this an appropriate thing to do or not may be impaired Whereas a smoker is not impaired in

Page 3225

that way while they are attempting to quit or while they are smoking
Q Is the treatment different as well, Doctor?
A Yes So that with someone who would be coming off of heroin, you would have to have -- you would want to monitor them very closely and use other medications in order to keep from having them to have severe withdrawal symptoms And I think the medical treatment for someone who is significantly dependent or dependent on heroin would be -- you'd have to follow that person much more closely than you would someone who was attempting to stop smoking
Q What's the percentage of smokers who quit, quit successfully on their own?
A Roughly 90 percent of smokers quit successfully on their own
Q If people believe or -- that it may be hard for them to quit, does it make it hard for them to quit or how does that affect their ability to quit smoking?
A Right. Well, I mean, if you go into, if you go into anything with a positive attitude, with a positive frame of mind, you're much less --

Page 3226

you're much more likely to succeed than if you go in with a negative frame of mind Some researchers have studied that kind of a -- they call it an expectation bias, where you expect something not to be pleasant and so it isn't pleasant And where you -- or if you expect you're going to do okay in something and it's going to be fine and you're not going to experience a bad side effect, then you probably won't

Q Can you explain why that happens? I mean, you mentioned studies

A Right

Q Tell us about those studies

A Well, if a person is going into quitting and they expect that they are going to do fine, they are going to expect that they are going to do well, then they don't have as much a problem quitting

So there have been some studies where they have taken individuals with nicotine gum -- placebo gum, or doesn't have an active ingredient, and nicotine gum which is an active nicotine gum And they mix those up so that the person doesn't know which one they are getting And then they

Page 3227

tell one group of people, you're going to get the active gum versus you're going to get the inactive gum The ones that they tell they are going to get the active gum, whether it's active or not, have less withdrawal symptoms than the other group

So that's commonly what's referred to as an expectancy bias, where a person expects that they are going to have a particular outcome and they have a better outcome

Q Why do people who get placebos -- is it placebos they are given?

A Well, they mix it up And where one group can get either placebo or active nicotine gum, the other group gets it, but there's an instruction before to the groups One's told that they will and the other one is told that they won't And those instructions actually play just as important a role and may be even more important a role than the active ingredient

Q And why does their expectancy about this have an effect on the symptoms that they report?

A Because those, many of those symptoms have psychological components to them, as well as physical components But the psychological

Page 3228

component is what can be adjusted and manipulated So if the person goes in feeling like they are going to be able to get through it and not have withdrawal symptoms, oftentimes the psychological component is abated and so you don't see those symptoms

Q How many people have quit smoking in the United States?

A I think it's -- now it's roughly 50 million people

Q Before those people who quit smoking made the decision to quit, were they dependent on smoking?

A Well, I don't think --

MR WILNER I object How could the doctor possibly know which people were which

THE COURT Sustained

Q Can you tell us, Doctor, whether those people were dependent or not?

MR WILNER Same objection

THE COURT I'll allow the answer

A I think it would depend on how you -- what kind of criteria you use to look at it If you had a liberal interpretation of criteria, you might say if they all smoked they would be, you

Page 3229

know, they would all be dependent If you had a more strict interpretation of it, you could say that none of them were It just depends on how you look at it

But certainly those people who quit, you wouldn't be able to say that they had a maladapted pattern of use They used when they wanted to and they were able to quit and now they are not using anymore

Q Did those people who quit, did they -- we talked about personalizing the risk Those people who quit, did they personalize the health risk of smoking?

A I can't --

MR WILNER I object

THE COURT Sustained

Q Well, what does it mean to personalize --

A Well, it means --

Q -- risk?

A It means to take into account, you know, everything about yourself, really I mean, an individual -- you know, each of us has different personal beliefs and goals in life and whatever those things are that are important to us So

Page 3230

it's putting your priorities in the context of smoking cigarettes or doing whatever behavior and determining which one of those is affected by it and whether or not you want to change

Everybody has a different view of that and it just depends on what's personal for that particular individual

Q And when people -- when a smoker personalizes the risk of, the health risk of smoking, does that help motivate them to quit smoking?

A Yes I mean, that's, that's a formula for them to quit, if they personalize those risks and the scale falls in the direction of not smoking versus smoking They are trying to weigh that decision out Maybe not every single time they smoke a cigarette Maybe they are weighing it out, you know, every day or maybe every few days or so when they think about it, you know, and say, well, is it, is it time to do this or not

And so when that -- when those risks become personal and individual to that person, it's much more likely that they quit

Q And why is it -- why does personalizing the risk motivate somebody to quit?

Page 3231

A I think it really depends on -- from person to person whether or not that -- why that, why that causes them to quit or why that allows them to quit

Q Has -- you've read Mr Carter's medical records and his deposition testimony, correct?

A Uh-huh (affirmative)

Q Has Mr Carter, based on what you've seen, personalized his risk into -- for health problems due to his diet?

A Not that I can tell He appears still to have a reasonably high cholesterol level that his doctors have been recommending him to make dietary changes And they are reporting in the record that he's still not compliant with those dietary changes

Q Can you compare for us, Doctor, the degree to which the package insert that you've been shown was a personal message or personal warning to Mr Carter to the degree to which the the warnings he got from his wife? Can you compare that for us?

A Okay Well, I mean, you know, this is more of an abstract concept The concept that, you know, if you read this, you will get -- you

Page 3232

know, you may get all these terrible things that could possibly happen to you I think, again, that's an abstract concept that he may put into the future, whereas the warnings that his family members were giving him were personal warnings by friends and family members and you would think would be more important

Q Why would they -- why would the warnings from his family, from Mrs Carter, for example, be more of a personal warning than the package insert?

A Well, well, she's his wife Of course, it's going to be more personal for her to be concerned about it than for him to read a piece of paper

Q What about the warnings that he received from his son Larry Carter? Which warnings were more personal, the warnings from Larry or the warnings in the package insert?

A Well, I would say that the warnings from Larry were more personal I mean, he had talked to his dad on many occasions, from what I can understand in the record, and tried to convince him that he should change his behavior And Mr Carter many times didn't heed that or didn't take

Page 3233

it seriously He had heard it a number of times from him and after a while stopped reading some of the information that was sent to him

Q How about the warnings he received from his doctors, Dr Jones, was that a more personal warning than the package insert?

A Well, I think a warning from your personal physician is a more personal warning, is a warning that you're more likely to heed, if you have a relationship with a patient and you've been dealing with that patient for a time

And I think that anybody who was suggesting that someone would stop smoking would say that if a person's personal physician asked them to stop smoking or requested that they stop smoking, that that's, you know, that's an important factor to consider

MR WILNER Excuse me, Your Honor I didn't object fast enough But vague as to time We'd just like some specification as to when we're talking about in this long period of time

Q The warning he received from Dr Jones --

A Yes

Q -- when he was at the FAA

Page 3234

MR WILNER Excuse me, Your Honor Could we get a date or something about these warnings, please

Q Doctor, do you know -- were those warnings given in 1980s, 1983, 1984?

A Yes, 1980s

Q How about the video from the actor on the Perry Mason show? Was that a personal-type warning?

A Yes I mean, it had a -- it had a -- definitely had an effect on me when I watched it I mean, I was concerned and moved by it and I think anyone would be when they saw it

Q Was this a more personal warning than the package insert that you've been shown?

A Yes

Q And can you explain why that video was a more personal warning than the package insert?

A Well, it describes the man and his children And he's very ill, obviously And it appeals to an individual's emotions to be able to look at that and recognize that that individual may not be there with his children, to raise his children or to see his children So it's definitely a more personal way of looking at it

Page 3235

Q When Mr Carter did quit smoking -- let me ask you -- what's the reason Mr Carter quit smoking in 1991, but that he didn't quit before that?

A Well, I think that we have addressed that, but I'll go over it again In 1991 I don't think that he could any longer push off the idea that he was not going to be affected by his smoking That he was going to be able to go through life being the two out of three instead of the one out of three, that he was going to be able to say, well, I'll stop tomorrow or I'll do this at a later date When that happened he was -- I'm sure he was scared and he was concerned and he was also, you know, shocked by the prospects and that motivated him to quit

Q Is that when he personalized the risk of smoking?

A Certainly

Q Is that what finally persuaded him or motivated him to quit?

A Yes

MR RILEY No further questions, Your Honor

THE COURT Okay Cross-examination,

Page 3236

Mr Wilner

MR WILNER Your Honor, may I have a moment to set up?

THE COURT Yes, sir

(Brief pause)

MR WILNER May it please the Court.

THE COURT Yes, sir

CROSS-EXAMINATION

BY MR WILNER

Q Dr Thompson, good afternoon

A Good afternoon

Q I believe we met about a month ago, New Orleans, when I took your sworn testimony at that time Do you remember?

A Yes

Q And I think you said that you had been contacted on this case about six months before that?

A Uh-huh (affirmative) Yes

Q I think you told me -- or let me just ask you You have never published anything on cigarette smoking, true?

A That's correct

Q And you have -- the patients that you deal with in this addiction or this -- that you

Page 3237

used to deal with in the addiction behavior unit were being treated primarily for what?

A They were being treated primarily for substance use disorders

Q Including nicotine?

A Yes Some of them did smoke and they also wanted to stop smoking

Q But were any of them being treated only for nicotine dependence or nicotine addiction?

A No I wouldn't treat someone for nicotine addiction in an inpatient substance abuse unit

Q Anybody? You wouldn't treat anybody for nicotine dependence or nicotine addiction as an inpatient, right?

A That's correct

Q Because it's just not that kind of an addiction, right?

A It doesn't meet the severity and the withdrawal symptoms are not severe so as to have to ward off lethal side effects

Q So you've never had a patient who you were treating primarily for this problem?

A No, that's not true I've had -- I have had patients who wanted to stop smoking and both

Page 3238

at Ochsner and at the present hospital where I work there are patients that want to stop smoking There are groups that they can attend and then we'll consult with those groups in order to either prescribe nicotine gum or describe patch, if it's something that the patient wants and feels that that's part of what they need

But it's not a major focus of what I do I don't run a nicotine cessation clinic, that's correct, or smoking cessation clinic

Q And patients who see pulmonary doctors and who may be smoking cigarettes and wish to quit, do you get referrals from pulmonary doctors to see these patients --

A No, I do not

Q -- to treat them for nicotine addiction or dependence?

A No, I do not

Q So who sits through the day and day trials and tribulations of the ones who are attempting to break the habit? Who? I mean what kind of doctor?

A Who sits through the day --

Q Yeah

A It depends on, I think -- many

Page 3239

physicians, I think, are interested in getting individuals to stop smoking

Q Well, I mean, I guess what I was asking, many physicians, but that is not your primary job, right?

A No, it's not

Q Now, actually the patients that you see now are generally psychiatric patients, right?

A Yes, that's true

Q And these patients have had -- they have either been declared -- they are criminally charged and placed in the facility, they are incompetent to stand trial or they are not guilty by reason of insanity; right?

A That's one population, yes

Q What's the other population?

A Outpatients that I see at the Tulane Clinic on Wednesdays

Q Okay And this Feliciana Forensic clinic, this includes people with psychiatric disorders, schizophrenia, bipolar disorders and that kind of thing, right?

A Yes, it does

Q Now, you are not suggesting in any of your testimony that Mr Carter suffers from one of

Page 3240

these mental diseases, are you?

A No, I did not

Q Now, is there a smoking cessation program at Feliciana Forensic facility?

A There is the -- one of the psychologists is -- has recently started up a group to help motivate folks to stop smoking, if they are interested I haven't been involved in setting that clinic up, per se

Q So you give lectures that deal with cocaine, alcohol and marijuana, but not with smoking, right?

A Yes

Q And you don't tell -- you're not the person who tells the people giving the stop smoking clinics what to present, right?

A That's correct

Q Have you ever sat down and written out an informational brochure to tell -- to work with people and give them information about how to get over this thing?

A No

Q You were given certain documents, I guess, to look at You told me about a couple of them I just wanted to make sure when you looked

Page 3241

at them One document that you were just -- that you were shown is in front of you and it's the package insert or the sample package insert that's been marked in this case?

A Yes

Q Do you see that?

A Yes, that's correct

Q When were you given that?

A I was -- I looked at it today, but I was given it, I think, yesterday

Q Yesterday?

A Yes

Q So you were here in Jacksonville yesterday awaiting this moment?

A Yes

Q Okay And how long have you been in Jacksonville?

A Since Thursday

Q Back just up at the hotel waiting to testify?

A I was under the impression that I might testify last Friday, and so I came in on Thursday

Q But nobody gave you this until yesterday?

A That's the first time I've seen it

Page 3242

Q What about these other documents? You mentioned some research done at Batelle Laboratories Do you remember that?
A Yes
Q When were you given that research?
A I think I saw that yesterday as well
Q Okay Did you know where that research came from?
A I think it was done at the Batelle Laboratory in Switzerland, I know that Where it came from originally? No, it came from -- I received it from the attorneys that I'm working with to review
Q Well, did you know that it was part of a set of documents that had been recently made publicly available from the University of Southern California?
A I understand that, but I -- it's not something that I knew when they were released
Q Did you make any attempt to look at the entire -- did you know how many documents have now been made public from the University of California as of 1995 that were -- the documents set that those particular ones were taken from?
A No, I do not know the number

Page 3243

Q Did you know that it was available on a CD-ROM disk or over the Internet, the whole set of documents?
A No Well, I've come to learn that I didn't know that, you know, when it was available
Q So you -- have you made any attempt to inquire as to the significance of these documents in connection with the entire set on CD-ROM or Internet or published in other publications?
MR. RILEY Objection, Your Honor Calls for speculation Assumes there is any significance
THE COURT Overruled
Q Have you?
A I've only reviewed the ones that I've given you information on
Q Now, the documents that you reviewed -- we'll talk about them in more detail in a minute But weren't they the subject of editorials in the Journal of the American Medical Association?
A I was aware of that today when you showed me an article from the American Medical Association that said that they were -- those documents were -- that they were reviewed or that there was an article about them But not until

Page 3244

today
Q And the title of that article that you learned about today was "Nicotine Addiction", right?
A Yes
Q And to this moment you've never read it?
A No, I have not reviewed every article in the literature
Q Well, I asked you just about this one
A No, I haven't reviewed that one
Q I mean, this is a 1995 publication in the Journal of the American Medical Association Is that a journal you get?
A Yes, it is
Q Have you undertaken some kind of a systematic study for this case to come in here and give testimony about these issues?
A Yes I did a literature search on Medline and then from there reviewed many different articles and reviewed Surgeon General's reports as well
Q And the Surgeon General's reports you reviewed were 1964 and 1988?
A Yeah, and portions of '79 and '90
Q Okay And the literature search that

Page 3245

you -- or the Medline search you did, that did not show up the 1995 Journal of the American Medical Association on nicotine addiction?
A No I was looking on -- under psychological issues, but I didn't see that particular article
Q Oh, you were looking under psychological issues?
A Yes
Q Which means like mind stuff, right? Why people do things, right?
A Actually, your mind is intimately connected to your brain, but yes
Q Well, I'm going to -- that was my next question I guess you got a little ahead of me there All right So you were looking at psychological questions?
A Yes
Q All right So -- well, you tell us What is -- what do you mean when you say psychological?
A Well, I mean there are, there are processes that occur that individuals deal with that have to deal with their everyday functioning and how they perceive them Psychological means

Page 3246

how the person perceives that particular -- the events that they go through on a daily basis, how do they perceive them with not necessarily the pharmacological issues that are concerned about that, but what are their everyday perceptions from their experiences, what they have gone through in their life and those kinds of things
Q Sort of the inner looking, what it feels like to do something, right?
A Sure That's part of it
Q Now, you got ahead of me in my question about psychological and the brain So let me see if I can give you a good question now Isn't it true that for centuries philosophers have agonized over the question of whether mind or body or brain controls human behavior? Isn't that fair?
A Yes
Q So isn't it true that many, many years ago people or scientists really did not understand that the brain might be the seat of or the origin of human behavior, right?
A Yes
Q In fact, there was a time when people thought the heart was what controlled what people did, right?

Page 3247

MR RILEY Objection, Your Honor I don't see any relevance to this He's just off on a tangent here
THE COURT Overruled
Q True?
A Yes, there were times when that was true
Q And in the last many years, I don't know, 50 years, perhaps, people have been studying more and more about what happens inside the brain, right?
A I think that's been, yes, an area of research
Q And the chemistry that happens inside the brain has been studied more and more, right?
A Yes
Q Now, isn't it true that what happens inside the brain, to oversimplify one of the biggest questions in human existence, what happens in here chemically has a reflection in what happens up here, right?
A Yes, those things reflect on each other. Your personal experiences reflect on your brain, your brain reflects on your personal experiences, yes

Page 3248

Q And the relationship between the mind and the brain is still something that philosophers and scientists may continue to debate for years, right?
A I would think so, yes
Q Now, isn't it true that today we have much more information about what goes on inside the brain, although we don't completely understand it, then we did 50 years ago?
A I would say yes
Q Now, when you looked at the literature you say on addiction, you looked primarily at the psychological side, right?
A Well, I looked at the psychological and there was pharmacological issues as well, certainly I mean, both of those are in the literature It's hard to separate them
Q Well, you said you did your search on psychological Do you want to change that?
A No, I don't want to change that But when I pull up articles, there are articles on both issues
Q This is what you did your key search on, though, isn't that right? Isn't that what you said?

Page 3249

A That's where I started
Q Okay And when you say there's another side, what did you call it, the pharmacologic?
A Well, I think that there are -- yeah, pharmacologic may be one
Q Pharmacologic We got a lot of little stuff on the board And pharmacology or pharmacologic means something to do with drugs, right?
A Yes
Q And there is a whole science of how drugs regulate or affect what happens inside the brain, right?
A Yes, there is a science about drugs that affect the brain
Q Now, are you coming here as an expert in the pharmacology of nicotine?
A No, I don't think that I came as an expert in the pharmacology of nicotine, but that doesn't mean that I didn't pay attention to that issue when I was reviewing the literature
Q I understand Okay I think -- oh, let me cover a few more topics You've testified -- you've been in court before, right?
A Yes, I have

Page 3250

Q You know where to sit and you know how to answer questions; right?
A Yes
Q And you know how to handle yourself in -- when you're asked questions by attorneys, right?
A I can answer questions and I can sit here, yes
Q And, in fact, you've been in about 50 cases, right?
A No, I wouldn't say 50 cases I've been in court approximately 50 times Many of those times were to talk to judges about medicating individuals and those kinds of things So there -- it just depends I have been in court on approximately 50 times, yes
Q And none of those times involved anything to do with cigarettes?
A No, they did not
Q And your fee, you said, was how much an hour?
A $300
Q And you're going to have $30,000 in charges, you figure, before you go home?
A Yes

Page 3251

Q And you have reviewed certain depositions that were given to you in this case?
A Yes, I have
Q Did you review the trial testimony that came from Mr and Mrs Carter?
A Yes
Q And you reviewed certain Surgeon General reports?
A Yes
Q Did you have the 1964 Surgeon General report yourself?
A No, I had to request that
Q How did you know that it even existed?
A Because when I went through the literature, the '64 Surgeon General report was mentioned and I asked for the '64 Surgeon General report and the '88 Surgeon General report because the issue was addiction versus dependence, and those kind of things, so I wanted to get enough information about those issues
Q And you also looked at this DSM, The Diagnostic and Statistical Manual I don't have the book, I just have a copy Do you have the book?
A Yeah, I have a copy

Page 3252

Q Okay So let me get this straight The Surgeon General report that you had to ask for from the attorneys, right?
A Yes
Q But what about that, that's yours, isn't it?
A Yeah
Q That DSM?
A Yes
Q Okay We're going to talk about that in a minute Anything else that you then -- and you did some research on psychological stuff You got -- you compiled some articles and you have those today, right?
A Yes
Q Okay Then yesterday you were given some documents out of Brown & Williamson's files and asked to look at those?
A Yes, I was
MR RILEY Objection, Your Honor No proof that they came out of Brown & Williamson's files
THE COURT Sustained
Q Now, Doctor, let me ask you just some general questions As I see this -- I understand

Page 3253

that you had on the board here -- pardon my copy of the '64, it's getting kind of dog-eared, but this is what it is, although you can't see it very well This is the 1964 Surgeon General report
A Okay
Q You might have had one that was copied on one side of the page, so maybe it was a little smaller
A Yes
Q But this is the best I've got
A Yeah
Q Okay So it seemed to me that you had up here a page 351 of this report which contrasted drug addiction with drug habituation, do you remember that?
A Yes
Q And we had -- I think the jury has seen that report in opening statement and other -- or rather that page in opening statement and other times, so we'll be able to move rapidly through it Is it fair to say, is it fair to say that you like -- you think the '64 Surgeon General's report was where you want to stay?
A I don't know that it's where I want to stay It was -- it appears to me a definition

Page 3254

that's more user friendly or that's easier to use when you're looking at these particular issues
Q So you would like to go out and say, I want to practice my field, or whatever it is, with the definitions that were in place in 1964 and not in 1996?
MR RILEY Objection, Your Honor That's not what he just said
THE COURT Overruled
A I don't want to practice medicine in general with those I just looked at these criteria versus the present criteria And I think these are much more reasonable as far as being able to distinguish the drugs that are addicting versus drugs that are more habituating
Q So to distinguish the drugs that are addicting from the drugs that are habituating -- and let me ask you then, why do you think you would want to do that?
A Why would I --
Q Why do you think you would want to distinguish drugs that are addicting from drugs that are habituating?
A Because I think it would, it would alter the way I treat patients It would alter the way

Page 3255

I look at those particular issues
Q So you would treat your patients differently if you viewed nicotine as addictive, is that right?
A No When I'm trying to decide whether to treat a patient, a particular patient who has a substance dependence disorder, it is easier to look and discriminate with these kinds of criteria than it is with the present criteria to know which ones to treat and which ones not to treat
Q Well, I guess I was curious You mean you -- do you apply this -- well, I'm confused When was the first time that you read the '64 Surgeon General's report?
A Probably six months ago
Q So, certainly, this is not something that you have used in your practice since you were treating patients, right?
A No, it's not I've used the DSMs to diagnose and treat patients
Q Well, I'm puzzled why you would say, then, that you like to go back and adopt the '64 Surgeon General report because it would help you treat patients Have you started -- have you changed the way you treat patients now that you've

Page 3256

read this '64 report?
A No, I have not.
MR RILEY Your Honor, I object. Compound question, but I think it also misrepresents the witness's testimony
THE COURT It was a compound question Ask one question, Mr Wilner
MR WILNER I apologize, Your Honor I asked the second one before -- it got out of my mouth before I had the chance to do it
Q Doctor, let me try -- see if I can clear this up because I am confused I said to you, why is it that you want -- that you would concern yourself with this, with addiction versus habituation And you said because it would -- I would treat my patients differently, right?
A I think if you use the criteria for substance dependence in the present nomenclature to talk about nicotine and caffeine, that you would include a group of people in there that you couldn't tell whether or not you would treat a certain way or not And with the other, with the other drugs I think it's much easier to distinguish those and you might be able to use criteria from the present literature and get a

Page 3257

reasonable opinion about those individuals and be able to tell which ones need inpatient treatment and which ones need outpatient treatment
Q I'm sorry, Doctor I must have -- maybe the hour is late I think I just didn't hear your whole answer So I'm going to have to try and break it down into two parts Because I know you tried to give me a complete answer, but I didn't -- I just couldn't process the whole thing at once So will you bear with me?
The first -- what I was asking you is why it would make a difference between drug addiction and drug habituation Can you answer that for nicotine, not for some other drug?
A Okay
Q Okay
A Why would it make a difference as far as treatment?
Q Yeah.
A For calling it addictive? It probably does not make a difference --
Q Oh, okay
A -- for treatment, as far as labeling one one thing or labeling one another thing
Q Okay Now, what about for the other

Page 3258

drugs then, heroin, cocaine, whatever else? Does it make a difference if you label them habituation or addiction?
A Well, no These are more labeling criteria But, I mean, diagnostic criteria would be the ones that you want to go by to treat someone
Q Well, wait We were back on -- I thought you told me that the difference between habituation and addiction would be important in the way you treated your patients, right? Didn't you say that?
A I did say that
Q All right Now I asked you, well, would it be important in the way you treat your nicotine-addicted patients, if you had any And you said no, right?
A I think that if you are looking at just the criteria to define a certain class, that it wouldn't make a difference necessarily in how you treat your patients
Q Okay
A I grant you that
Q All right So now we go to the next series of drugs other than nicotine, and I give

Page 3259

you the opportunity -- tell me the difference between habituation and addiction for the other drugs in the way you treat your patients Is there any?
A It's a way of defining those particular individuals so you know which ones have severe disorders and which ones do not I don't know that it would make a major difference in the way I treat patients, again, if I said that they were addicted versus they were dependent
Q Does the modern literature, including DSM-IV, make a distinction between habituation and addiction anymore?
A No, it does not
Q So if -- so I -- so prior to the time you read this 1964 book, were you making a distinction between habituation and addiction in your modern practice under DSM-IV which doesn't make that distinction?
A Well, the individuals who are habituated are often using nicotine and often using caffeine The individuals who are dependent or are addicted are often needing treatment that I provide So I'm providing those individuals treatment

Page 3260

Q Okay, Doctor I'm sorry I guess you answered that, but maybe I didn't ask my question very clearly and I apologize. It seemed to me that if we wound the clock back to the day before you were first contacted by the cigarette company attorneys --
A Uh-huh (affirmative)
Q -- you had -- you were sitting there and you certainly didn't have any knowledge of or care the first thing about the Surgeon General's report of 1964, right? True?
A Yes
Q All right So you were sitting there and you were practicing as a psychiatrist and you used the modern book of the time, which is DSM, The Diagnostic and Statistical Manual IV, right?
A Yes
Q And that came out when?
A That was 1994
Q All right And that does not make a distinction between habituation and addiction, right?
MR RILEY Your Honor, may I object to this and may we approach? He's --
THE COURT Yes, sir

Page 3261

(Side-bar conference is held outside the hearing of the jury)
MR RILEY Your Honor, he's just confusing the purposes of the DSM-IV The DSM-IV is used to diagnose patients and Surgeon General's report is not I think these questions are unfair The document served its purposes He's trying to compare them and that's not appropriate
THE COURT Well, that's not what the doctor said He said it would make a difference in how he treated people So I'm going to overrule the objection
MR SHEFFLER Your Honor, may I make a suggestion? We have one juror who is sound asleep and --
THE COURT I hadn't noticed Which one?
MR SHEFFLER Mrs King And I don't know -- Woody's cross I guess I shouldn't make this -- but at least we should have them stand up, if not take a break or something to get the juices flowing
THE COURT I appreciate it
MR WILNER It's been a long day
THE COURT It is a long day

Page 3262

MR WILNER Have a time estimate for anyone?
THE COURT With regard to?
MR WILNER Here, you know, today
THE COURT Well, the jurors may dictate --
MR WILNER Absolutely
THE COURT -- what it is
MR WILNER That's my point
THE COURT I don't -- it has been a long day It's after the hour that we normally stop Is the doctor available tomorrow?
MR SHEFFLER We'd like to finish today, if we can, Your Honor
MR WILNER There's no way I can finish today
THE COURT You bring to my attention that Mrs King is sound asleep, which it appears that she is at this moment I don't think she's been asleep very long
MR SHEFFLER No, that's absolutely correct, Your Honor I just thought maybe we could stand and stretch or just get the juices flowing a little bit
MR WILNER Your Honor, we can't --

Page 3263

THE COURT How long are you going to be?
MR WILNER At least another hour and a half, at least I can't finish him today
THE COURT Okay We're going to recess
(Side-bar conference is concluded, proceedings resume before the jury)
THE COURT Lady and gentlemen, it has been a long day We're going to stand in recess until 9 00 a m tomorrow morning
(Proceedings adjourned at 5 10 p m)

Page 3264

REPORTERS' COURT CERTIFICATE

STATE OF FLORIDA)
)
COUNTY OF DUVAL)

The following individually named reporters certify that we were authorized to and did stenographically report the foregoing proceedings and that the transcript is a true and complete record of our stenographic notes

We further certify the original transcript will be delivered to J W Prichard, Jr , Esquire, attorney for defendant for filing with the court or his safekeeping

DATED this 5th day of August, 1996

(Pages ___ through ___)
Georgia J Winegeart, RPR

(Pages ___ through ___)
Mary Kaminowski Huth, RPR